

MAIL TO:

Utah Department of Environmental Quality
 Division of Water Quality, ATTN: UIC
 P.O. Box 144870
 Salt Lake City, Utah 84114-4870

FAX TO: (801) 538 - 6016**EMAIL TO: CCADY@utah.gov**

Utah
 Underground
 Injection
 Control
 (UIC)

Inventory Information
 for

Well Class: _____

Facility ID No.: **FAC** _____

Risk: Hyd. _____ Chem. _____

 Date Entered: _____ By: _____
 (For DWQ use only)

Storm Water Drainage Wells

FACILITY LOCATION

Facility Name:					Phone:		
Facility Physical Address:						(City)	
Facility Mailing Address:					(City)	(Zip Code)	
Facility Geographic Location:	T.	R.	Section	1/4 of		1/4	
	Latitude:	Degrees	Minutes	Seconds	UTM Northing (Y): _____ m or ft		
	Longitude:	Degrees	Minutes	Seconds	UTM Easting (X): _____ m or ft		
County:						<input type="checkbox"/> NAD 83 or <input type="checkbox"/> NAD 27	

FACILITY CONTACT

Contact Name:					Phone:		
Contact Type: (check all that apply)	<input type="checkbox"/> Owner	<input type="checkbox"/> Operator	<input type="checkbox"/> Facility Manager	<input type="checkbox"/> Contractor / Consultant			
	<input type="checkbox"/> Legal / Official Rep	<input type="checkbox"/> DEQ Engineer	<input type="checkbox"/> Local Health Dept	<input type="checkbox"/> Other: _____			
Title:			Organization:				
Contact Mailing Address:					(City)	(Zip Code)	

Contact Name:					Phone:		
Contact Type: (check all that apply)	<input type="checkbox"/> Owner	<input type="checkbox"/> Operator	<input type="checkbox"/> Facility Manager	<input type="checkbox"/> Contractor / Consultant			
	<input type="checkbox"/> Legal / Official Rep	<input type="checkbox"/> DEQ Engineer	<input type="checkbox"/> Local Health Dept	<input type="checkbox"/> Other: _____			
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Contact Name:					Phone:		
Contact Type: (check all that apply)	<input type="checkbox"/> Owner	<input type="checkbox"/> Operator	<input type="checkbox"/> Facility Manager	<input type="checkbox"/> Contractor / Consultant			
	<input type="checkbox"/> Legal / Official Rep	<input type="checkbox"/> DEQ Engineer	<input type="checkbox"/> Local Health Dept	<input type="checkbox"/> Other: _____			
Title:			Organization:				
Contact Mailing Address:					(City)	(Zip Code)	

LAND OWNERSHIP AT FACILITY

<input type="checkbox"/> Private	<input type="checkbox"/> Public (State or Local)	<input type="checkbox"/> Tribal	<input type="checkbox"/> Federal: _____	<input type="checkbox"/> Other: _____
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LAND USE ZONING AT FACILITY

<input type="checkbox"/> Residential	<input type="checkbox"/> Commercial	<input type="checkbox"/> Manufacturing / Industrial	<input type="checkbox"/> Professional / Institutional	<input type="checkbox"/> Agricultural
<input type="checkbox"/> Open Space	<input type="checkbox"/> Public Lands	<input type="checkbox"/> Overlay Zones: _____	<input type="checkbox"/> Other: _____	

FACILITY DESCRIPTION

Primary SIC code: _____	or	NAICS code: _____	Secondary SIC/NAICS code: _____
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Description of Business Activity at Facility:

STORM WATER DRAINAGE WELL OPERATING STATUS (indicate number of wells in appropriate category)

Proposed	Under Construction / Modification	Active	Temporarily Abandoned	Permanently Abandoned

STORM WATER DRAINAGE WELL CONSTRUCTION AND SUBSURFACE DETAILS

Narrative Description of System Construction and Subsurface Details (see Instructions):

Depth to Ground Water: _____	Ground Water Class: _____
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STORM WATER CHARACTERIZATION

Storm Water Capture Area and BMPs Description (see Instructions):

Annual Storm Water Volume (gallons): _____
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COMMENTS**SIGNATURE**

Name & Title (print or type)	Phone Number
Signature	Date Signed